

Parent Questionnaire for Camp Woodlight 2018

Child's Name: _____

Date: _____

Birthday: _____

Grade in September 2018: _____

Welcome to Federation Early Learning Services! Please fill out this questionnaire to help us get to know your child and return it prior to placing your deposit for Camp Woodlight.

School/Camp History:

- What school does your child attend: _____

- Has your child attended a summer camp program before?

Yes No

If yes, please provide program information and why you are considering Camp Woodlight: _____

Health History:

- Does your child have any physical limitations (such as hearing, speech, vision, coordination)?

Yes No

If yes, please explain: _____

- Has your child ever had a serious injury or been hospitalized?

Yes No

If yes, please explain: _____

- Does your child have an IEP or receive help at school?

Yes No

If yes, please explain: _____

- Does your child receive services that will occur during the camp program?

Yes No

If yes, please explain: _____

Behavior/Emotions:

- Can your child occupy him/herself, and for how long?

Yes No

If yes, please explain: _____

- How does your child express frustration and/or anger? _____

- How does your child react to new situations? _____

- Please list your child's favorite activities: _____

- Does your child have any special skills or talents? _____

- How would you describe your child? (Please check all that apply)

- | | | | | |
|--------------------------------------|------------------------------------|------------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Shy | <input type="checkbox"/> Friendly | <input type="checkbox"/> Excitable | <input type="checkbox"/> Leader | <input type="checkbox"/> Affectionate |
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Passive | <input type="checkbox"/> Curious | <input type="checkbox"/> Tense | <input type="checkbox"/> Demanding |
| <input type="checkbox"/> Independent | <input type="checkbox"/> Obedient | <input type="checkbox"/> Stubborn | <input type="checkbox"/> Funny | <input type="checkbox"/> Confident |
| <input type="checkbox"/> Sensitive | <input type="checkbox"/> Immature | <input type="checkbox"/> Caring | <input type="checkbox"/> Cheerful | <input type="checkbox"/> Destructive |
| <input type="checkbox"/> Follower | <input type="checkbox"/> Courteous | <input type="checkbox"/> Calm | <input type="checkbox"/> Jealous | <input type="checkbox"/> Withdrawn |

Play and Social Interactions:

- Does your child:

Share well with others Yes No

Take Turns Easily Yes No

Follow an adult's directions Yes No

Move easily from one activity to another Yes No

Respect the rights and property of others Yes No

Defend him/herself Yes No

Take responsibility for his/her actions voluntarily Yes No

- Please describe how your child does academically and socially in school: _____

Medical Information:

- Has your child ever had a serious injury or been hospitalized?

Yes No

If yes, please explain: _____

- Allergies and Reactions:

- | | | | |
|---------------------------------------|------------------------------|-----------------------------|-----------------|
| <input type="radio"/> Bee stings | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Reaction: _____ |
| <input type="radio"/> Penicillin | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Reaction: _____ |
| <input type="radio"/> Hay Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Reaction: _____ |
| <input type="radio"/> Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Reaction: _____ |
| <input type="radio"/> Skin Condition | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Reaction: _____ |
| <input type="radio"/> Foods (specify) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Reaction: _____ |

Notes: _____

- Diet Restriction for Medical Reasons: _____

- Diet Restriction for Religious Practices: _____

- Activity Restrictions: _____

- Distinguishing birthmarks: _____

- Medications taken regularly: _____

Parent Name (Please Print): _____

Parent Signature: _____

Date: _____

Parent Email: _____

Parent Phone Number: _____

Enrollment Coordinator Signature: _____

Date: _____